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**Work-role transition: From staff nurse to clinical nurse
educator.**

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requirements for the degree of**

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Abstract

There is an imperative for health professionals today to maintain competence in clinical practice, which for registered nurses in New Zealand requires current experience of practice, continued professional development and education. In many organizations in New Zealand today, practice based clinical education for nurses is delivered by clinical nurse educators (CNEs). The purpose of this study was to explore the opinions and perceptions of CNEs as they transitioned from a staff nurse position to the CNE role, a designated senior position within the District Health Board (DHB) involved in this study.

The aim of the study was to describe the experiences of CNEs in their first year in the role to gain a clearer understanding of the knowledge and skills required to be successful in the role. This understanding will enable a smoother and more satisfactory transition into the role and provide targets for career development for nurses aspiring to become CNEs. Qualitative description, using a general inductive approach was the methodology chosen to underpin this study. A sample group of eight CNEs from a New Zealand DHB were interviewed about their experiences using a semi structured interviewing technique.

The results of the data analysis have been presented using Bridges (2003, 2004) transition theory as the theoretical framework. The data chapters are titled endings, neutral zone and beginnings. The main themes were; entering transition, getting started, chaos and turmoil, overwhelmed and opening doors. The themes present the feelings and perceptions of the CNEs using their own words. The CNEs experienced the journey through transition and discovered the role they had undertaken was much larger than expected. In addition information and shared understandings of the role were limited and orientation to the role, minimal. The CNEs experienced a variety of emotions and challenges while moving through this transition period. By sharing their stories and insights they have given the opportunity for learning to occur, which will enable improved succession planning, orientation and transition periods for future CNEs.

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Chapter 1: Introduction

1.1. Introduction

In New Zealand's District Health Boards (DHBs), the workload of the staff nurse¹ continues to evolve and increase (McCloskey & Diers, 2005). Concurrently there are increasing numbers of learners in the clinical setting; new graduates, nurses returning to practice, overseas nurses, student nurses and newly appointed nursing staff, who the staff nurse is expected to support or precept. As bed management responsibilities, highly dependent patients, increasingly complex treatment options, sub optimal skill mix and financial restrictions all impact on nursing time, it can be difficult to sustain the role of preceptor and teacher (Brennan & Hutt, 2001; Edmond, 2001; Orchard, 1999). Many DHBs have responded to the need to orientate nurses, manage clinical risk, provide ongoing practice education and meet the regulatory requirements of continuing competence, as required by the Nursing Council of New Zealand (NCNZ), by establishing Clinical Nurse Educator (CNE) roles embedded across the various specialty areas.

The Health Practitioners Competence Assurance Act (HPCAA, 2003) requires all registered health professionals in New Zealand to provide ongoing evidence of competence within a scope of practice as detailed by their regulatory body. This has led the nursing regulatory body (NCNZ) to request evidence of practice and education hours on a three yearly basis from each practising registered nurse in New Zealand. In a competitive recruitment market access to in-house education is a potential recruitment and retention strategy as nurses seek access to free education opportunities to meet continuing competence requirements for their annual practising certificates.

In light of the HPCAA (2003) there has been considerable national activity in DHBs to develop Professional Development and Recognition Programs (PDRPs) to facilitate competence assessment of registered nurses, enrolled nurses and nursing assistants. A number of DHBs have had PDRPs for many years based on Benner's (1984) model of situational skills acquisition applied to the nursing profession. There has also been some use of magnet principles, which relate to the recruitment and retention of nurses (McClure, Poulin, Sovie, & Wandelt, 1983). PDRPs require evidence of learning hours

¹Throughout the thesis the researcher will refer to registered nurses employed in non designated positions as staff nurses. Registered nurses in designated positions will be referred to as senior nurses, or a title specific to their role such as clinical nurse specialist.

and practice skills, linking professional development, performance management and competence assessment (Peach, 1995, 1999). In many DHBs CNEs are the leaders of the PDRPs and competence assessment, their key role being to link practice education with clinical need.

CNEs are often professionally isolated as there is usually only one CNE in a service. However, CNEs have much in common with their colleagues from different clinical specialties. An example of this commonality is their transition into a senior role, which can be demanding and complex regardless of nursing specialty. This study presents the experiences and perceptions of a group of CNEs as they moved into this diverse senior role. In this chapter the background to the study is explored through presenting the CNE role within an historical context. Researcher interest and study aims are also presented. The chapter concludes with an overview of the thesis. The significance of the study is presented in the following section.

1.2. Significance of the study

Continuing practice development and education is vitally important in the rapidly changing practice setting of healthcare (Evetts, 1999). The CNE role provides an avenue for DHBs in New Zealand to offer continuing practice development and education within the clinical setting. Clinical practice can be complex, stressful and fast paced, hence a deep understanding of the clinical context is vital for any education or resource role (Edmond, 2001). CNEs, as DHB employees, have clinical credibility and full organizational access. They are able to effect change in practice, are involved in decision making, performance management and policy development. The combination of organizational knowledge, networking and clinical expertise provides an expedient resource for the staff working in the clinical area (Cowin, 2003; Edmond, 2001). The CNE has a significant role to play in quality assurance activities, staff assessment, clinical practice development, risk management and support for individual staff members. All these components ultimately impact on patient outcomes and the provision of quality nursing care.

The CNE is a nationally designated leadership position within the DHB nursing structure. As nurses ascend through the nursing hierarchy, their responsibilities and the expectations of them become more intense and more complex, but frequently less clear

(Laborde, 2000; Porter-O'Grady 2003a). It is often the case that nurses who have performed well in clinical practice are expected to perform well in designated senior positions, for which they have often had no formal preparation (Wilson, 2005). It is clear that employees perform better when they and their managers have a deeper understanding of how their roles function (Ministerial Taskforce, 1998). Despite this diverse role existing in New Zealand's DHBs for a number of years there is a paucity of literature available to describe the role. This study will increase the understanding of the role for employers and CNEs themselves, leading to stronger planning for future roles, succession planning initiatives and comprehensive, tailored orientation programmes.

1.3. Researchers interest in the study

Interest in this research stemmed from personal experience as a CNE, and then as the professional leader of clinical nurse and midwife educators. I have gone through my own chaotic and vulnerable time when moving from a staff nurse position to my first senior nursing role. During that time, I read a quote from an article which resonated with me then and continued to have relevance as I moved into other senior roles. "Becoming a nurse educator is not an additive process; that is not a matter of adding the role of educator to that of nurse. It requires a change in knowledge, skills, behaviours and values to prepare for newly assimilated roles, settings and goals shared by new reference groups" (Infante, 1986, p. 94).

To establish a rationale for undertaking the study, I have referred back to a discussion with a number of CNEs from my own DHB who had either completed one year in the role or were just about to. CNE orientation, leadership and provision of toolbox skills to do the job, are a part of my role and responsibilities. These conversations were informal and occurred due to my role and type of interaction with CNEs, looking at how we could improve the orientation for new CNEs. We talked about how they felt moving into their new roles and how they had grown into them. I requested permission from the CNEs to use their words anonymously in the study as a point of introduction and rationale, they enthusiastically agreed. I grouped their responses into 4 categories, using their own words.

(1) Feelings upon starting in the role

- Feel completely de-skilled, standing on the edge of a cliff looking out onto the 'big picture.'

- I had a complete lack of understanding of the size and scope of it ... it's huge.
- I went from 'top of the heap' clinical expert/ support/ resource/ coach to novice CNE.
- It felt very lonely, but also like I was in the spotlight and having to prove myself.
- Surprised at the agendas people had for me, the expectations were overwhelming.
- You have to juggle. They want you to be setting up and running study days, writing policy and on the wards all at the same time.
- You feel guilty whatever you do, either if you're 'visible' or 'not visible'.

(2) Personal developments

- Always need to be accessible, always welcoming.
- Learning to stay neutral.
- How to coach and teach.
- Counselling skills/ mediator/ diplomacy.
- You need organizational knowledge and awareness really quickly ... networking is so important.
- Viewing your old colleagues through a different lens.
- Being relied on.
- Learning leadership skills, like decision making, self awareness and managing relationships.
- Getting used to 'being seen differently', behaviours change when you walk into their area.
- People have to trust you and you have to earn that.
- The first year is a massive learning curve. Can't believe how much I just didn't know.

(3) Tasks

- The computer skills—excel data-basing, email scheduling, power-point.
- Learning how to write using the quality template ... that was time consuming and stressful, and I didn't know I'd have to do that.
- Representing your service or even the DHB in various meetings, nobody tells you about that.
- What various 'must attend' meetings are for, where they fit, it took a while to work out.
- Staff assessment skills-or the communication skills to undertake assessment.

(4) The first year: the CNE's agreed on a timeline for their own development.

- 0-6mth- self-direction, finding out what the job is, feeling vulnerable.

- 6-9mth- starting to make sense of things, but overwhelmed.
- 9-12mth- starting to consolidate what you've learned, starting to 'do the job'.

In my capacity as the professional leader for this group I was aware of the inconsistency and ad hoc manner of CNE orientation. I continue to hold the opinion that orientation should not take a set period of time to suit the convenience of the organization, but rather, should be revisited and adjusted as often as the individual requires. I have encouraged nurses who are new to designated senior positions to maintain a journal in their first year as a tool to enable reflection. These reflections value and celebrate the completion of a journey, of which I have personal experience.

1.4. Research question and aims of the study

Question

- What are the perceptions and opinions of nurses as they transition from staff nurses into being clinical nurse educators?

Aims

- To describe the experiences of CNEs in their first year in the role.
- To develop a clearer understanding of skills and knowledge required to be a clinical nurse educator.
- To guide the development of a process to make this transition period more successful and satisfactory.
- To develop a more targeted approach to career development for people aspiring to the role of CNE.

1.5. Background

In order to present this study in context I have explored the development of the CNE role in New Zealand. As the CNE is a designated senior position it was important to put the evolution of the role into the historical, socio-political context of nursing leadership while being mindful of the requirements to provide post registration clinical education. Two main areas are presented, clinical education post registration and the impact of the health reforms on nursing in New Zealand.

1.6. Clinical education post registration.

There is a richness of information available describing the development of New Zealand nursing education, from hospital based training to the undergraduate degree programmes of today (Brown, Masters & Smith, 1994; Department of Health, 1986; NZNA, 1984; Orchard, 1999; Papps & Kilpatrick, 2002; Williams, 2000). The Carpenter report (Carpenter, 1971) recommended an alteration in registered nurse training, moving from hospital training to a polytechnic based course. In 1973 Christchurch and Wellington Polytechnics commenced nursing courses in response to the Carpenter recommendations. Over the subsequent years polytechnic based training continued to supplant hospital based training until the last hospital based school of nursing, Auckland, closed in 1990. Resistance to the loss of students as a workforce with their transfer to polytechnics was observed across New Zealand as nurses defended the system under which they had gained registration (Papps & Kilpatrick, 2002).

The loss of the student nurse workforce altered the staffing balance in the clinical environment. Difficulties in recruiting the correct mix of registered nurses, enrolled nurses and healthcare assistants to replace the student workforce, saw a decline in the numbers of senior nurses, registered and enrolled nurses (McCloskey & Diers, 2005). This decrease in numbers of registered nurses and enrolled nurses led to increased pressure on remaining staff to manage high workloads, preceptor new graduate nurses and support colleagues (Brown et al., 1994; Ministerial Taskforce, 1998; NZNO, 1995).

There is little written on the continuing practice education of registered nurses in New Zealand. Williams (2000) outlines the development of nursing career structures in New Zealand generally and the developments in pre and post registration nursing education. For example, as far back as 1965 nursing 'inservice education' positions were established to manage ongoing education and orientation of registered nurses. Their role was to ensure nurses in practice could refresh their skills. In later years, inservice departments ensured that nurses could safely return to practice and were also able to support new graduate nurses as they left the polytechnics. The courses offered by these departments did not result in qualifications towards career progression but, instead, kept nurses up to date in their particular field of interest (NZNA, 1984, 1987).

The NZNA review of inservice education (1987) detailed the development of inservice departments. They defined inservice education as a means of ensuring the nurse was more effective in the workplace. Organizations were obliged to provide this service and nurses were obliged to participate. The career structure for staff within inservice departments was outlined by the NZNA (1987). The expectation was that inservice staff would attain post registration diplomas or degrees in nursing, and the head of the department should have a post graduate qualification in nursing. The inservice educators were expected to be clinically current and have skills in policy development and knowledge of adult educational practices. Inservice departments realized nursing practice had changed as a result of workforce restructuring (NZNA, 1987) and that the need for ongoing education and orientation to new clinical environments, employer policies and procedures, was of paramount importance to maintain safety. The NZNA (1984, 1987) identified that most large organizations had an inservice department which needed to become central to an organization in order to cope with a changing work environment.

Despite being seen as central to nursing education in the 1980's the advent of the health reforms in the 1990s saw the demise of the inservice departments due to extensive budget cuts. Nursing was the largest workforce and its budget, including nursing education, was extensively trimmed (McCloskey & Diers, 2005). Nursing staff from inservice departments were redeployed or made redundant.

The loss of the hospital based schools of nursing had significant and irreversible impacts on the nursing hierarchy and the overall structure of nursing (Jacobs, 2003). Nurse leaders took the opportunity to seize the moment to be the driving force for their own future (Williams, 2000). For example as new graduates left the polytechnics and needed ongoing support nurse leaders sought to deliver education working alongside the registered and enrolled workforce in the clinical environment. In the mid eighties the first senior clinicians were appointed, a precursor to the clinical nurse specialists of today. In 1988 supervisor roles were removed and the first of the nurse specialist roles was introduced. Between 1991 and 1993, with burgeoning specialties and increasing clinical complexities, clinical nurse specialist and clinical nurse educator roles began to increase in number across New Zealand's hospitals (J. Peach, personal communication, October 4, 2006).

1.7. Health reforms

Health reform can be described as a reconfiguration of the health system at a national level (Bloom, 2000). In New Zealand health reforms were announced in July 1991 and aimed to introduce market competition into a publicly funded health system (Hornblow, 1997). The New Zealand health reforms looked at service costs, efficiency and quality of health service delivery, and were driven by political agenda's, increasing financial costs within the health care system, advances in technology, increasing consumer knowledge and expectations. The government of the time claimed that market tension would increase performance of the twenty three newly developed Crown Health Enterprises, which were expected to operate at a profit. This resulted in contract negotiations for services, budget cuts and increased user charges (Hornblow, 1997). Nursing services, being the largest within the organizations, attracted aggressive budget cuts, a phenomenon repeated in other parts of the world, such as North America (McCloskey & Diers, 2005; Tourangeau, 2003).

Inevitably, in reforming the health system, organizational staffing structures were challenged and changed. The reforms, aimed at controlling the spiraling cost of healthcare through market competition, had widespread and sometimes unpredicted consequences such as the decline in the quality of patient care as registered and enrolled nursing numbers dropped and nursing leadership at every level of the health system was lost (McCloskey & Diers, 2005). A decline in registered nurse staffing levels has since been internationally proved to be a leading cause of adverse patient outcomes, nurse job dissatisfaction and stress in the hospital setting (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Cho, 2001; McCloskey & Diers, 2005).

The reforms not only focused on the cost of health care delivery but challenged traditional roles in hospital management. Historically the management system utilized by New Zealand's hospitals was a tripartite model; a doctor, a nurse and an administrator (Alexander, 2000). The development of the health care market led to a professional management model, which saw a number of doctors and nurses moving into management roles (Alexander, 2000; Peach, 1995). According to Peach (1995) many senior nurses were removed and managers introduced. However, some senior nurses opted to move into management roles. Williams (2000) suggests that many senior nurses did not have the skills or support to successfully move into management, or

struggled with the adjustment to the different demands of management roles (Kaissi, 2005) leading to some leaving the profession. Other senior nurses left to take employment in technical institutions as lecturers and tutors. Again Williams (2000) suggests many found this a difficult transition. Significant numbers of staff nurses, enrolled nurses and senior nurses left the profession altogether (Brown et al., 1994). According to Williams (2000) nurse leaders of the time are of the opinion that a generation of expert clinicians was lost. The Ministerial Taskforce, (1998) noted that nursing leadership had significant gaps, and in acknowledging the future global workforce issues in nursing, the Taskforce document recommended development of professional career pathways, increased access to further education, leadership development and increased understanding by employers of nursing roles.

The change of guard at the hospital management level had significant impact on nursing as a whole. In presenting a history of nursing at the time, Brown et al. (1994) note that this signalled a change in roles for charge nurses, from being responsible for the nursing care of the patients to recruitment and managing a budget. Conversely, the organization's senior nurse or chief nurse was seen in an advisory capacity only, often losing budgets completely, while the hospitals were run by generic managers (McCloskey & Diers, 2005).

In some instances, managers would have professional health backgrounds (clinician/managers) which impacted on decision making processes. Clinician/managers who felt able to knowledgeably balance clinical versus financial implications could and would make decisions without consulting clinicians, including the organization's chief nurse. However, many of the managers were business managers and conflict occurred as nurses' professional values and the business managers' commercial values collided (Alexander, 2000; Hornblow, 1997). Remaining nursing leaders felt de-valued and rather than having involvement in corporate and strategic decision making, they lost financial and strategic control of nursing (Ministerial Taskforce, 1998).

At this stage, nursing leadership was unable to regain the level of management and financial control it held prior to health reform (McCloskey & Diers, 2005). However, in recent times, opportunities for senior roles within nursing have increased. Workforce development pressures, such as changing consumer needs, technological advances,

and recruitment issues, have opened the door for new roles to evolve, such as; Nurse Consultant, Associate Directors of Nursing and the Nurse Practitioner. Nursing leadership has again seized the opportunity to develop career structures for nurses, and to shape its own future.

1.8. Organization of the thesis

Chapter one: Introduction

In chapter one the study is introduced and the context of the CNEs place in DHBs in New Zealand is described. The researcher's interest in the study is presented introducing the rationale for the study. The background to the study provides an historical context for the role in ongoing practice education, nursing leadership and the health reforms. An overview of the thesis completes the chapter.

Chapter two: Literature review

In chapter two, a critical review of the literature relevant to this study is presented. The role of the CNE and similar roles internationally begins the section; nursing leadership and succession planning are also presented. In keeping with the theoretical framework chosen for this study the literature on transition in nursing practice is reviewed along with an overview of literature on organizational socialization and orientation.

Chapter 3: Research process

In chapter three the research methodology and methods are presented, beginning with an overview of qualitative research, specifically qualitative description. The ethical issues and the approval process associated with the study are presented. The interview and sampling methods are detailed and an overview of the general inductive data analysis process, followed by a section on rigour and trustworthiness. The chapter concludes with an overview of the theoretical framework used to present the findings.

Chapter four: Endings

Chapter four begins the data presentation chapters. The first section reviews the endings stage of transition then the chapter is split into two themes, 'entering transition', and 'getting started'.

Chapter 5: Neutral zone

In chapter five, the data relating to the neutral zone phase of transition are presented. Beginning with a review of the neutral zone and then moving into the theme of 'chaos and turmoil' followed by the final theme, which relates to 'being overwhelmed'.

Chapter 6: Beginnings

In chapter six the data relating to the beginning phase of transition are presented. It starts with a review of the beginning stage of transition and then the theme of 'opening doors' is presented. This is the last of the data chapters.

Chapter 7: Discussion of findings.

In chapter seven the discussion generated by the study and the recommendations from the findings are presented. They are discussed within the context of nursing in DHBs in New Zealand and the literature reviewed for this study. The recommendations and limitations of the study are acknowledged and the concluding statement presented.

1.9. Summary

In this chapter an introduction to the CNE role was provided, situated in the rapidly changing and turbulent health environment of New Zealand's DHBs. The current spotlight on competence assessment following the introduction of the HPCAA (2003) has an increased focus on the provision of in-house education and professional development opportunities. This study is significant as the CNE role plays an important part in providing competence assessment, quality assurance, risk management and practice education within DHBs. The researcher's experiences in the CNE role sets the scene for the basis of the study.

The development of the CNE role was placed into an historical context by reviewing the development of nursing education and inservice education departments in New Zealand. Changes in student education, removal of the student workforce, and the health reforms of the 1990's, resulting in economic constraints and altered management structures, had significant impact on nursing. In the following chapter a literature review is presented, which includes literature about the CNE role, succession planning and leadership, concluding with a review of the literature on transition and organizational socialization.